STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-13648 QHP
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared as Authorized Representative for [redacted] (Appellant).

Representing [redacted], (hereafter, 'Medicaid Health Plan' or 'MHP') were [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for breast reduction surgery?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. The Appellant is a [redacted]-year old female with a history of organic sleep apnea, seizure disorder, rheumatoid arthritis, osteoarthritis, gout, morbid obesity, hypothyroidism, cerebral vascular accident and cardiomyopathy. She also has a family history of breast cancer. The Appellant stands 5 feet 1 ½ inches in height and weighs 308 lbs, with a bra size of 50-E. The Appellant complains of tenderness of neck and shoulder, shoulder grooving, breast heaviness, and maceration of the inframmatory fold. The Appellant also suffers from degenerative

changes in her spine, particularly her cervical spine. *(Exhibit 1, Attachment 3)* The Appellant's pain symptoms are well controlled through the use of narcotic analgesic pain medications (Vicodin). *(Exhibit 1, Attachment 4)*

3. On [redacted], the MHP received a prior authorization request from [redacted] requesting coverage for Reduction Mammoplasty (bilateral breast reduction) for the Appellant. The documentation received at the time of the request included a letter of request, a short progress note from [redacted] and photographs of the Appellant. *(Exhibit 1, Attachments 5, 6 and 7)*

4. On [redacted], an MHP utilization management consultation with the MHP Medical Director ([redacted]) commenced regarding the request. There was no supporting medical documentation provided to assist the MHP in making a medically sound decision whether to approve the requested breast reduction, such as Body Mass Index, child bearing desires, psychiatric assessment, inability to perform activities of daily living, other specific physician-prescribed therapeutic measures, or evidence that the Appellant, given her obesity and other medical issues, had been medically cleared for surgery.

5. The [redacted], consultation also lacked medical evidence of the Appellant's attempts at losing weight, or that a weight reduction or nutritional counseling program had been attempted.

6. On [redacted], the MHP denied the Appellant's request for Reduction Mammoplasty, and recommended a referral to Weight Watchers, and offered custom-fitted bras to accommodate the Appellant's large breast size. *(Exhibit 1, Attachment 9)*

7. On [redacted] the Appellant submitted her Request for Hearing to the State Office of Administrative Hearings and Rules for the Department of Community Health.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

Midwest Health Plan is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List

omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverage(s) and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.

The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

- An annual review and reporting of utilization review activities and outcomes/interventions from the review.

The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, September 30, 2004.

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services. An MHP must also provide its members with the same or similar services

and/or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual.

Reduction Mammoplasty falls within Medicaid Provider Manual policy governing cosmetic procedures. Cosmetic surgery is a Medicaid covered service, given the following articulated conditions.

> **13.2 COSMETIC SURGERY**
>
> Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:
>
> - The condition interferes with employment.
> - It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
> - It is a component of a program of reconstructive surgery for congenital deformity or trauma.
> - It contributes to a major health problem.
>
> The physician must identify the specific reasons any of the above criteria are met in the PA request.
>
> *Michigan Department of Community Health*
> *Medicaid Provider Manual; Practitioner*
> *Version Date: April 1, 2009*
> *Page 64*

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

MHP witnesses provided credible evidence that its denial of Reduction Mammoplasty is predicated upon a lack of any medical documentation establishing that the Appellant has attempted weight loss as a method of relieving the strain on her neck and back muscles. The MHP also established that the Appellant failed to provide documentation establishing whether her large breasts are the only cause of her neck and back pain, and whether, at a minimum, she may safely undergo surgery, given her medical history and more importantly, her morbid obesity. For example, the MHP provided radiographs of the cervical spine that clearly indicate the Appellant suffers from degenerative changes to the cervical spine, a condition that may, in fact, be the cause of her discomfort. *(Exhibit 1, Attachment 3)*. Thus, it cannot be concluded that the Appellant's breast size is the sole, or proximate cause of her back and neck pain.

In contrast, the Appellant's physician asserted the MHP's criterion are merely a "gimmick" to deny otherwise medically necessary services. This approach to establishing medical need does nothing to assist the trier of fact in adjudicating the merits of the Appellant's claim that her large breasts must be reduced in size in order to alleviate her suffering.

The Appellant's physician also failed to produce evidence that would otherwise support a conclusion the Appellant's breast size interferes with activities of daily living, that they are a component of reconstructive surgery to address either a congenital deformity or trauma, that they contribute to major health problems or that they interfere with employment.

Based on the aforementioned analysis, I conclude the MHP has properly denied the Appellant's request for Reduction Mammoplasty.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Appellant has failed to establish, by a preponderance of the evidence presented, that her request for Reduction Mammoplasty is medically necessary.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

[redacted]
Docket No. 2009-13648 QHP
Hearing Decision & Order

[redacted]

Date Mailed: 4/23/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.